TEMPORARY NURSING SERVICE AGENCY REGISTRATION APPLICATION

Dear Applicant: Complete this application and return it with your check and any required documentation to:

Pearlina Mills, Program Coordinator
Department of Public Health, Division of Health Care Quality
99 Chauncy Street, 2nd Floor
Boston, MA 02111

The Department will review your application. If your application is complete and acceptable, including payment as required, the Department will assign a registration number effective the date of receipt of your application.

If you will be operating at more than one location, you must complete a separate registration application for each additional location.

A. REGISTRATION INFORMATION:

1. _____
Temporary Nursing Service Agency Name (name by which you will do business)

2. _____
Applicant (Individual Owner, Partnership, Limited Partnership, Corporation Name)

3. _____
Address From Which Agency Will Do Business in Massachusetts (Street, City/Town, ZIP)

4. _____ 5. _____
Telephone Number Fax Number

6. _____
Administrator's Name

B. APPLICATION TYPE:

____ Initial registration of new temporary nursing services agency.

____ Change of ownership for existing temporary nursing services agency, registration number ☐☐☐☐. (Attach copy of bill of sale or other documentation of change of ownership.)

C. ADDITIONAL LOCATION INFORMATION

____ This is the agency's only or primary location.

____ This will be an additional location for the agency:

___ Existing primary location registration number ☐☐☐☐, or:

____Proposed new primary location: _____
(Street, City/Town, ZIP)

D. OWNERSHIP INFORMATION

1. Applicant's Ownership Structure – *Please check one:*

___ Sole Proprietorship (Individual)

___ Partnership

___ Limited Partnership

___ Other (please specify) _____

___ Charitable (non-profit) Corporation

___ Corporation (for profit)

2. If the owner is a partnership, limited partnership or corporation of any nature, please provide the nine digit identification number as registered with the Massachusetts Secretary of State's office:

☐☐☐☐☐☐☐☐☐

3. If a corporation, please list the officers and directors of the corporation:

a. _____ b. _____
Name Title

c. _____
Address (Street, City/Town, State, ZIP)

d. _____ e. _____
Name Title

f. _____
Address (Street, City/Town, State, ZIP)

g. _____ h. _____
Name Title

i. _____
Address (Street, City/Town, State, ZIP)

j. _____ k. _____
Name Title

l. _____
Address (Street, City/Town, State, ZIP)

(Attach list of any other officers or directors.)

4. Owner's Name(s) – *Please provide information on all individuals with a 5% more ownership interest.*

a. _____ b. _____
Name Ownership Interest (% owned)

c. _____
Address (Street, City/Town, State, ZIP)

d. _____ e. _____
Name Ownership Interest (% owned)

f. _____
Address (Street, City/Town, State, ZIP)

g. _____ h. _____
Name Ownership Interest (% owned)

i. _____
Address (Street, City/Town, State, ZIP)

(Attach list of any additional 5% or greater owners.)

E. DISCLOSURE OF PRIOR OPERATION OF A TEMPORARY NURSING AGENCY:

Have any of the corporate officers, directors, or owners listed in parts D.3 and D.4 previously owned or operated a temporary nursing agency which failed to file a cost report in a timely manner, or had its registration denied or revoked?

____ No ____ Yes (If yes, indicate below:)

Individual(s) involved: _____

Agency Name: _____

Agency Address: _____

Agency registration number ☐☐☐☐.

(Attach listing of other agencies or individuals as needed.)

F. REGISTRATION FEE – *The registration fee for a temporary nursing service agency is $750. The registration fee for each additional location is $300.* ***Please submit one check, payable to "Commonwealth of Massachusetts" for all registration fees.***

Check number: _____ in the amount of: _____ attached as payment for:

____ Initial registration of Temporary Nursing Service Agency
____ Additional locations, if any (submit a completed application for each additional location).

G. SIGNED AND NOTORIZED STATEMENT OF APPLICATION – *105 CMR 157.110 requires all applications for the initial registration of a temporary nursing agency be notarized and signed under the pains and penalties of perjury.*

In accordance with the "Regulations for the Registration and Operation of a Temporary Nursing Service Agencies", 105 Code of Massachusetts Regulations 157.000, the undersigned applies for registration to establish and maintain a temporary nursing service agency at the premises set forth above under the provisions of Massachusetts General Laws Chapter 111, section 72Y.

As the applicant, or authorized agent or representative of the applicant, I hereby certify that I am aware of the obligation of temporary nursing service agencies under 105 CMR 157 to:

- Be administered by a person qualified by training, experience or education.
- Maintain regular hours of operation.
- Provide services to health care facilities under the terms of a written agreement.
- Establish policies to ensure personnel are currently registered, licensed or certified as required.
- Establish policies to verify personnel have had pre-employment physicals and testing for communicable diseases as required by the health care facility prior to assignment.
- Maintain records on employees, to include evidence of a background check which at a minimum will consist of a Nurse Aide Registry, and CORI check for persons with direct access to residents, patients or clients.
- Maintain written procedures for assigning personnel.
- Establish a policy for annual performance assessments of employees.
- Report suspected drug tampering or diversion; poor nursing practices; and suspected violations of the Massachusetts Patient Abuse Law as required.
- Provide access to the Department of Public Health to agency records upon request or at the time of an inspection.
- File cost reports with the Division of Health Care Finance and Policy in a timely manner.

I further certify pursuant to Massachusetts General Laws Chapter 62C, section 49A that, to the best of my knowledge and belief, the applicant has filed all state tax returns and paid all state taxes as required under state law.

Temporary Nursing Service Agency – Initial Application

I, _____ , the undersigned applicant or authorized agent for the above-named temporary nursing service agency, do hereby certify that all the information contained herein is true and correct as of the date shown below. SIGNED UNDER THE PENALTIES OF PERJURY, this _____ day of _____ , 20 _____.

_____
Applicant or Authorized Agent's Signature

_____
Applicant or Authorized Agent's Printed Name and Title

Subscribed and sworn to before me this _____ day of

_____ , 20 _____.

_____
Notary Public

My commission expires on _____, 20_____. _____ (Seal)

FOR DPH USE ONLY:

_____
DATE APPLICATION RECEIVED

_____
Temporary Nursing Service Agency

_____
Address

APPROVED: _____

FROM: _____

THROUGH: _____

PRIMARY LOCATION: _____

ADDITIONAL LOCATION: _____

REGISTRATION NUMBER:

☐☐☐☐

OWNERSHIP CHANGE: YES ☐ NO ☐

DENIED: _____

1. ___ Application Incomplete
2. ___ Unable to Verify Corporate Status
3. ___ Application Not Signed/Notarized
4. ___ Check Not Enclosed/Wrong Amount
5. ___ On OIG Excluded List
6. ___ Other: _____

CC: Health Care Finance & Policy
DHCQ – Survey Processing Unit
DHCQ – Nurse Aide Registry